



California Newborn Hearing Screening Program Diagnostic Audiologic Evaluation Reporting Form

Please complete this form and Fax to 562-933-8157 or Mail to the Southern California Hearing Coordination Center, 2801 Atlantic Avenue, Long Beach, CA 90806, within seven days of the child's diagnostic Audiologic Evaluation. **DO NOT** attach waveforms, OAE printout, audiograms or reports. If the family does not appear for the scheduled appointment and you have difficulty in rescheduling the outpatient hearing screening, please contact the Hearing Coordination Center at 562-933-8152.

Infant's Name: _____ Date of Birth: _____ Date of Eval.: _____
AKA: _____ Gender: ☐ F ☐ M Medical Record No.: _____
Birth Hospital: _____ ☐ WBN ☐ NICU
Primary Care Provider (PCP): _____ Phone: _____
Parent or Legal Guardian: _____ Phone: _____
Address: _____ Zip: _____

Test Results: Indicate all components that apply. Diagnostic evaluations should be completed as per the California Infant Audiology Assessment Guidelines and the Joint Committee on Infant Hearing Year 2000 Position Statement.

	RIGHT	LEFT
Average/Estimated Hearing Level (500-4kHz)	<input type="checkbox"/> Normal 0-20 dB <input type="checkbox"/> Mild 21-40 dB <input type="checkbox"/> Moderate 41-70 dB <input type="checkbox"/> Severe 71-90 dB <input type="checkbox"/> Profound 91+ dB	<input type="checkbox"/> Normal 0-20 dB <input type="checkbox"/> Mild 21-40 dB <input type="checkbox"/> Moderate 41-70 dB <input type="checkbox"/> Severe 71-90 dB <input type="checkbox"/> Profound 91+ dB
Type of Hearing Loss <i>Leave blank if hearing is normal</i>	<input type="checkbox"/> SNHL <input type="checkbox"/> CHL <input type="checkbox"/> permanent <input type="checkbox"/> transient <input type="checkbox"/> Mixed <input type="checkbox"/> Auditory Neuropathy/Dys-synchrony <input type="checkbox"/> Undetermined/testing not completed next appt*: _____	<input type="checkbox"/> SNHL <input type="checkbox"/> CHL <input type="checkbox"/> permanent <input type="checkbox"/> transient <input type="checkbox"/> Mixed <input type="checkbox"/> Auditory Neuropathy/Dys-synchrony <input type="checkbox"/> Undetermined/testing not completed next appt*: _____

* Should be scheduled ASAP, program goals include diagnosis of hearing loss by 3 months of age and entry into Early Intervention services by 6 months.

Discussion: _____

Amplification Status: ☐ Not Required ☐ Not Recommended ☐ Recommended ☐ Refused

Explain: _____

Other Diagnoses Related to Hearing Loss: _____

Plan/Follow-up appt.: _____

Referral to ENT: Date: _____ Physician: _____ Phone: _____

Referral to CCS: Yes: Date: _____ ☐ Application ☐ Request for Service ☐ County: _____

No: Already known to CCS _____ County: _____

Referral to Early Start (1-866-505-9388): Date: _____ Hearing loss information given to parent/guardian: ☐ Yes ☐ No

Parent/Guardian refused services: Yes Refused by: _____ Date: _____

Parent/Guardian Contact Attempts: Document at least 3 attempts to contact the family.

1. Contact: ☐ Mail ☐ Phone ☐ Fax Date _____ Result: _____

2. Contact: ☐ Mail ☐ Phone ☐ Fax Date _____ Result: _____

3. Contact: ☐ Mail ☐ Phone ☐ Fax Date _____ Result: _____

Audiology Facility: _____ Phone: _____ Fax: _____

Audiologist Name (Print) _____ Signature _____ Lic.# _____

Please complete all relevant information. Incomplete forms will be returned.

This information is to be provided pursuant to Section 124119 of the California Health and Safety Code that requires you to report the results of audiological follow-up services provided through the California Newborn Hearing Screening Program.